



Your child is enrolled in a center that participates in the Child and Adult Care Food Program (CACFP). By participating in this Program, the center follows Federal meal pattern requirements and receives reimbursement to assist with food costs. The CACFP requires that parents provide specific enrollment information on an annual basis. This form will be placed in center files and treated as confidential information.

Revised 6/2016

Iowa Child and Adult Care Food Program Child Care Enrollment Form

Last Name, First Name	Birthdate	Times of Care		Regular Days of Care							Meals Served During Care					Ethnicity/Race*			
		Arrival	Departure	M	T	W	Th	F	S	S	B	AM Sn	Lu	PM Sn	D	E Sn	Ethnicity	Race	

*Ethnicity (Select one and enter in the chart above): H=Hispanic or Latino or N=Not Hispanic or Latino
 Race (Select one or more and enter in the chart above): W=White, B=Black or African American, I=American Indian or Alaska Native, A=Asian, and P=Pacific Islander
 This information is requested by the Federal Government in order to monitor compliance with civil rights law. You are not required to furnish this information, but are encouraged to do so. The law requires that a program recipient may neither discriminate on the basis of this information nor on whether you choose to furnish it. However, if you choose not to furnish it, this Program representative is required to note race/ethnicity on the basis of visual observation or surname.

Infants only (0 to 12 months): I am not enrolling an infant (skip this section)

As a participant in a USDA Child Nutrition Program, our center offers meals to children of all ages. Infant feeding is based on current nutrition guidelines. Infant foods are appropriate for the age and developmental readiness of your infant. Please select (X) your choice(s) of the following options that will fulfill your infant's food needs.

- I will provide breastmilk for my infant. Center formula may be used to supplement feedings if necessary: Yes No
- I will provide infant formula for my infant. Name of formula: _____
- I accept the center's formula for my infant. Name of formula: _____
- I will provide a statement from a prescribing medical authority for non-reimbursable formula. Name of formula: _____
- I accept the center's solid foods (appropriately textured) to be served to my infant as s/he is ready for them, and after I have discussed it with the caregiver.
- I will provide solid foods for my infant*. The center may supplement with additional solid foods when my infant needs them: Yes No

*The parent may provide no more than one reimbursable food item in order for the center to claim the meal. DHS licensed centers must follow CACFP infant meal pattern requirements regardless of who supplies the food. Your center can provide a copy of the CACFP infant meal pattern and a list of reimbursable foods upon request.

Parent Signature _____ Date: _____

Parent Signature _____ Date: _____ (Make any needed changes above, sign and date)

Parent Signature _____ Date: _____ (Make any needed changes above, sign and date)

USDA is an equal opportunity provider and employer.

Iowa Eligibility Application

Complete one application per household. School Year 2016-2017

FFY 16-17

Part 1. Check all applicable boxes:

- | | | |
|--|--|--|
| <input type="checkbox"/> school meals | <input type="checkbox"/> children in child care center | <input type="checkbox"/> children in child care home(HP) |
| <input type="checkbox"/> special milk (restrictions apply) | <input type="checkbox"/> Tier I home provider (HP) | Provider name: _____ |
| | <input type="checkbox"/> Head Start/Even Start | |

Part 2. Check if any child is Homeless, Migrant, or a Runaway and call your child's school. Run away Migrant Homeless

Part 3. FIP or Food Assistance Eligible: Enter the FIP or Food Assistance Case Number for ANY household member as listed in the Notice of Decision. NOTE: Medicaid, Title XIX and EBT card numbers are not acceptable. Skip part 5.

Name of household member with Case Number _____ List Case Number _____

Part 4. Children enrolled. REQUIRED OF ALL APPLICANTS.

List name(s) of all enrolled child(ren) in your household.							
Last Name	First Name	Middle Name or Initial	Check box for FOSTER child <input type="checkbox"/>	Date of Birth	Grade	OPTIONAL	Name of School/Head Start/Child Care Center/Home
						ETHNICITY	
1.			<input type="checkbox"/>				
2.			<input type="checkbox"/>				
3.			<input type="checkbox"/>				
4.			<input type="checkbox"/>				
5.			<input type="checkbox"/>				

Part 5. Total Household Gross Income. DO NOT COMPLETE PART 5 IF YOU LISTED A FIP OR FOOD ASSISTANCE NUMBER IN PART 3. Report the gross income received by EACH household member one time in the correct column: weekly, every 2 weeks, twice a month or monthly. Gross income is the amount earned before taxes and other deductions, not take-home pay. Report all other monthly income received. Self-employed persons, see the worksheet on reverse side of this application.

List the names of <u>everyone</u> living in your household, including the children listed in Part 4. Attach a separate page if more space is needed. For FOSTER children, include only money available for child's personal use or child's own income.					Gross Income: Report income by how often the household member is paid.				Other Monthly Payments or Income Received.		
Last Name	First Name	Age	Check if NO Income <input type="checkbox"/>	Gross amount earned weekly	Gross amount earned every 2 weeks	Gross amount earned twice a month	Gross amount earned monthly	Welfare, child support, alimony, adoption subsidies	Pension, retirement, social security, SSI, VA benefits	All other income	
1.			<input type="checkbox"/>								
2.			<input type="checkbox"/>								
3.			<input type="checkbox"/>								
4.			<input type="checkbox"/>								
5.			<input type="checkbox"/>								

Last four digits of my Social Security Number: X XX - X X - ____ ____ ____ I do **not** have a Social Security Number.
If Part 5 is completed, the adult signing the form must provide the last 4 digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. For further information refer to the Privacy Act Statement in the parent letter.

Part 6. Certification and Signature. REQUIRED OF ALL APPLICANTS.

I certify (promise) that all information on this application is true and that all income is reported if required. I understand that I will receive benefits from Federal funds based on the information I give. I understand that officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal/milk benefits, and I may be prosecuted. Email of Adult Completing Form _____

Signature of Adult Completing Form _____ Printed Name of Adult Completing Form _____ Date Signed _____

Address of Adult Completing Form _____ Town _____ ZIP Code _____ Work Phone _____ Home Phone _____ Cell Phone _____

Part 7. DO NOT WRITE BELOW THIS LINE. FOR ADMINISTRATIVE USE ONLY.

Income conversion factors for annual income: weekly X 52; two weeks X 26; twice a month X 24; monthly X 12
Household Income: \$ _____ Weekly Every 2 Weeks Twice Monthly Monthly Annually Household Size _____

Application Approved:	<input type="checkbox"/> Income <input type="checkbox"/> Foster Child (free)	<input type="checkbox"/> FIP/Food Assistance	CACFP HP ONLY: <input type="checkbox"/> Tier 1 Area (Provider's own children)
	<input type="checkbox"/> Head Start DOCUMENTATION REQUIRED	<input type="checkbox"/> Homeless/Migrant/Runaway (Schools only)	
Eligibility Determination:	<input type="checkbox"/> Free Meals <input type="checkbox"/> Reduced Price Meals	<input type="checkbox"/> Free Milk	<input type="checkbox"/> Tier 1 Income (All children)
Application Denied:	<input type="checkbox"/> Incomplete <input type="checkbox"/> Over income limits		<input type="checkbox"/> Tier 1 Child (Tier 2 mixed)

Determining Official Signature _____

Effective Date _____

hawk-i/Medicaid Information Form: Read this information and sign if you do not want your name released to hawk-i or Medicaid.

If your children do not have health insurance, many families getting free and reduced price meals can also get free or low-cost health insurance for their children.

The law requires schools to share your free and reduced price meal eligibility information with Medicaid and *hawk-i*, the State's medical insurance program for children. Specifically, we will give them your child's name and your name and address. Medicaid and *hawk-i* can only use the information to identify children who may be eligible for free or low-cost health insurance and then to contact you. They are not allowed to use the information from your free and reduced meal application for any other purpose.

Childcare organizations may share this information at their option.

You are not required to allow us to share information from your children's free and reduced price meal application with Medicaid or the *hawk-i* program. It will not affect your children's eligibility for free and reduced price meals. If you do NOT want your information shared with Medicaid or *hawk-i*, you must tell us by completing the information below at the time you complete this eligibility application. If you want further information, you may call *hawk-i* at 1-800-257-8563.

I DO NOT want school/home sponsor/child care or Head Start center officials to share information from my free and reduced price meal application with Medicaid or *hawk-i*. Also, if you are already receiving Medicaid or *hawk-i*, please sign below. This will avoid another contact.

Child's Name: _____ School/Child Care/Head Start Center: _____

Child's Name: _____ School/Child Care/Head Start Center: _____

Child's Name: _____ School/Child Care/Head Start Center: _____

Parent/Guardian Name (Printed) _____ Signature _____ Date _____

Self-Employment Income Worksheet: This worksheet will assist you in calculating the amount to report if you engage in farming, are self employed, or have income from other sources.

Persons who are engaged in farming or who operate other types of private businesses may experience variations in cash flow or monthly income throughout the year. These persons may use their income tax records from the preceding calendar year as a basis for applying for the free and reduced price meals. The income to be reported is income derived from the business venture less operating costs incurred in the generation of that income. Deductions for personal expenses such as medical expenses and other non-business deductions are not allowed in reducing gross business income.

If you have additional income from other kinds of employment, this income must be treated as separate and apart from the income generated from your business venture. USDA **DOES NOT** recognize income the same way as IRS. USDA does not permit a loss from a business venture to off-set earnings from wages or salary. Though your business may have suffered a net operational loss, for purposes of this application, it is not possible to have a negative income. **The least self employed income possible is zero (no income).** For example, if you operated a business at a net loss but held another job where you received wages, your income for purposes of applying for free or reduced price meals would be the income from your wages only. The loss from the business cannot be deducted from the amount of the income earned in the other job.

A prior year loss from farming or other private business operation cannot be used to reduce the current year net income for determining free and reduced price eligibility. Wages paid to a spouse or other family member in the operation of a farm or private business must be shown as household income in Part 5 of the application.

Income from private business operations is to be taken from your most recent U.S. Individual Income Tax Return - Form 1040. Use the lines from the 1040 that are identified.

Line 12 - Business income or (loss)	\$	
Line 13 - Capital gain or (loss)	\$	
Line 14 - Other gains or (losses)	\$	
Line 17 - Rental real estate, royalties, partnerships, S corporations, trusts, etc.	\$	
Line 18 - Farm income or (loss)	\$	

Total \$ _____

The least income possible is zero (a negative number cannot be reported)

Total ÷12* = _____

*Enter amount in the "All Other Income Last Month" column in Part 5 on the front of the Iowa Eligibility Application.

Optional Waiver Information (for Schools only)

Iowa CACFP Child Care Center Parent/Guardian Letter - Non-pricing (front) 7/2016

Purpose: The attached Iowa Eligibility Application is used to determine eligibility for free and reduced price meal reimbursement. The instructions for completion are on the back of this letter.

Dear Parent or Guardian:

This center participates in the Child and Adult Care Food Program (CACFP) administered by the United States Department of Agriculture (USDA). Participants are not charged separately for meals. However, by participating in this Program, the center receives partial reimbursement for nutritious meals served to children. The amount of reimbursement the center receives is determined by the information you provide. Providing information can help your center purchase nutritious food. Higher reimbursement will be given to the center for meals served to enrolled children from families whose income is at or below the level shown in the chart below. Please read the instructions on the back, complete, sign and return the attached income application as soon as possible. An application that does not contain all required information cannot be used by the center. If required information is missing, free or reduced-price meal benefits will be denied. Call your center if you need help with the form. The information reported on this form will be filed and treated as confidential.

A foster child who is the legal responsibility of a welfare agency or court may be certified as eligible for free meals regardless of your household income. See instructions on the back for more information.

If you do not qualify now to receive free or reduced price meals, you may apply for benefits at any time during the year. If you have a decrease in household income, have an increase in family size, or have enrolled children that become eligible for food assistance or FIP, you may fill out an application at that time.

Income Eligibility Guidelines for Reduced Price Meals Effective 7-1-2016 to 6-30-2017

Household Size	Reduced Price Meals				
	Yearly	Monthly	Twice per Month	Every Two Weeks	Weekly
1	\$21,978	\$1,832	\$916	\$846	\$423
2	\$29,637	\$2,470	\$1,235	\$1,140	\$570
3	\$37,296	\$3,108	\$1,554	\$1,435	\$718
4	\$44,955	\$3,747	\$1,874	\$1,730	\$865
5	\$52,614	\$4,385	\$2,193	\$2,024	\$1,012
6	\$60,273	\$5,023	\$2,512	\$2,319	\$1,160
7	\$67,951	\$5,663	\$2,832	\$2,614	\$1,307
8	\$75,647	\$6,304	\$3,152	\$2,910	\$1,455
For each additional family member add:	+\$7,696	+\$642	+\$321	+\$296	+\$148

Privacy Act Statement: This explains how we will use the information you give us.

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. The last four digits of the social security number of the adult household member who signs the application must be listed. The social security information is not required when you apply on behalf of a foster child or if you list a Food Assistance number, or Family Investment Program number, or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the CACFP. We may share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

USDA Nondiscrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](http://www.ascr.usda.gov/complaint_filing_cust.html), (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
- (2) fax: (202) 690-7442; or
- (3) email: program.intake@usda.gov.

Instructions for Completing Iowa Eligibility Application

Complete both sides of an application for each household.

All applicants should complete Part 1. This application may be used to apply for benefits in school meals or milk programs, child care centers and home based care for children. Check all boxes that apply to your family. You may make copies of a completed application for each program in which your child participates.

FIP OR FOOD ASSISTANCE HOUSEHOLD MEMBER, including child(ren) in Head Start or Even Start, follow these instructions.

Part 3. List one FIP or Food Assistance **Case Number** per household in the area provided. **Use the Case Number listed in the DHS Notice of Decision.** Eligibility based on Head Start or Even Start is available only if your child is enrolled in Head Start and documentation from the Head Start agency is provided. **NOTE: Medicaid, Title XIX and EBT card numbers are not acceptable.**

Part 4. List the name, date of birth, grade (if applicable), name of school/Head Start/child care center attended for each child in your household. Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of your child's ethnic and racial status if you do not complete this section.

Part 5. Skip this section.

Part 6. Read the certification and complete this section.

HOMELESS, MIGRANT OR RUNAWAY, follow these instructions.

Part 2. For children attending school, check if any child is Homeless, Migrant, or a Runaway and call your child's school.

Part 4. List the name, date of birth, grade (if applicable), name of school/Head Start/child care center attended for each child in your household. Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of your child's ethnic and racial status if you do not complete this section.

Part 5. Skip this section.

Part 6. Read the certification and complete this section.

FOSTER CHILD IN HOUSEHOLD, follow these instructions. A foster child is a child who is living with a household but who remains the legal responsibility of the welfare agency or court. Foster children can be included as household members or included on a separate application.

Part 4. List the child's name, date of birth, grade (if applicable), name of school/Head Start/child care center attended. Check the box for foster child. Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of your foster child's ethnic and racial status if you do not fill this section.

Part 5. Complete this section only if the foster child receives money for personal use or has other regular personal income. If the foster child has no income, check the box indicating no income. **DO NOT** include the stipend received by the foster family to provide care to the foster child.

Part 6. Read the certification and complete this section.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions for reporting income.

Part 4. List the name, date of birth, grade (if applicable), name of school/Head Start/child care center/home attended for each child in your household. Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of each child's ethnic and racial status if you do not complete this section.

Part 5. Follow these instructions to report total household income from last month.

Name: List the last and first names of **each** person living in your household, related or not (such as grandparents, other relatives, or friends); include yourself and all children living with you. The household decides whether to include the foster child on their household application with non-foster children. Attach another sheet of paper if needed.

Age: List the age of each household member.

Check if No Income: Put a mark in the box if the household member **does not** have an income.

Gross Income last month and how it was received: Report the amount of income received in the appropriate Gross Income column (weekly, every 2 weeks, twice monthly, or monthly). List the **gross income** each person earned from work. This is not the same as take-home pay. **Gross income is the amount earned before taxes and other deductions.** The amount should be listed on your pay stub, or your boss can tell you. If you have a household member for whom last month's income was higher or lower than usual, list that person's expected average income. If the household includes the foster child, they must report any personal income received by the foster child on the foster parent's household application.

Other Monthly Payments or Income: Money is reported in this section if it is regularly received. List the amount each person received last month from welfare, child support, alimony, adoption subsidies, pensions, retirement, Social Security, Supplemental Security Income (SSI), and Veteran's benefits (VA benefits). In the **All Other Income** column, include Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, cash withdrawn from savings, investments or trusts, interest and **ANY OTHER INCOME.** Use the Self-Employment Income Worksheet on the back of the application to calculate net income for self-owned businesses, farm, or rental income and report in the **All Other Income** column. **Do not report:** Scholarships, educational benefits, lump sum payments, combat pay, Deployment Extension Incentive Pay (DEIP) or children's incidental income from occasional activities such as babysitting, shoveling snow, or cutting grass. If you are in the Military Housing Privatization Initiative or get combat pay do not include these allowances.

Social Security Number: If the application is being made on the basis of income, the adult signing the form must provide the last 4 digits of his or her Social Security number or mark the "I do not have a Social Security number" box. If you do not provide your Social Security information or mark the box, your application cannot be processed.

Part 6. Read the certification and complete this section.